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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 2010-606

12 **FLORIBEL BRIOSOS DIAZ**
13 **306 Deanne Lane**
Daly City, CA 94014
14 **Registered Nurse License No. 450436**

ACCUSATION

15 Respondent.

16
17 Complainant alleges:

18 PARTIES

19 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
20 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department
21 of Consumer Affairs.

22 2. On or about March 31, 1990, the Board of Registered Nursing issued Registered
23 Nurse License Number 450436 to Floribel Briosos Diaz ("Respondent"). The Registered Nurse
24 License was in full force and effect at all times relevant to the charges brought herein and will
25 expire on April 30, 2012, unless renewed.

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1 8. California Code of Regulations, title 16, section 1443, states:

2 "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the
3 failure to exercise that degree of learning, skill, care and experience ordinarily possessed and
4 exercised by a competent registered nurse as described in Section 1443.5."

5 COST RECOVERY

6 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
7 administrative law judge to direct a licentiate found to have committed a violation or violations of
8 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
9 enforcement of the case.

10 STATEMENT OF RELEVANT FACTS

11 10. On September 8, 2008, patient N.Y.¹ was admitted to San Francisco General
12 Hospital Medical Center ("SFGH"), in San Francisco. She had a large pelvic tumor consistent
13 with ovarian cancer and had been recently diagnosed with colon cancer.

14 11. Surgery began at 1:40 p.m. on September 8, 2008. N.Y. underwent a total abdominal
15 hysterectomy with removal of her fallopian tubes, ovaries and a large portion of her intestinal
16 tract. N.Y.'s surgery was complicated by a massive intraoperative hemorrhage. Surgery was
17 concluded at 10:05 p.m., lasting 8 hours and 25 minutes.

18 12. Respondent at all relevant times was employed as a registered nurse at SFGH. On
19 September 8, 2008, at 7:55 p.m., she was assigned as the scrub nurse in the operating room for
20 N.Y. She remained the scrub nurse until N.Y. left the operating room at 10:05 p.m.

21 13. Respondent affirmed with the circulating operative room nurse that at the time the
22 surgeons began closing and prior to the completion of the closing, that the counts were correct for
23 all "SHARPS/NEEDLES/SPONGES AND INSTRUMENTS." One of the type of surgical
24 sponges used during N.Y.'s operation is known as a "lap sponge" that has a radiopaque tag such
25 that if retained, it can be identified by x-ray.

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27 ¹ Patient initials are used to protect the patient's privacy. Full names will be disclosed to
28 Respondent pursuant to a request for discovery.

1 14. N.Y. returned to SFGH on December 12, 2008, complaining of a foul smelling
2 vaginal discharge. A pelvic examination revealed the presence of a foreign body adhering to her
3 wall of her vagina. It was removed and sent to pathology for identification. The removed object
4 was identified to be a lap sponge with a radiopaque tag.

5 FIRST CAUSE FOR DISCIPLINE

6 (Gross Negligence – Incorrect Sponge Count)

7 15. Respondent is subject to disciplinary action for gross negligence under section Code
8 section 2761, subdivision (a)(1) in that she failed to accurately complete the final lap sponge
9 count, did not identify the loss of a lap sponge and failed to notify the surgeons of the incorrect
10 sponge count as set forth in paragraphs 10 through 14, above. Respondent's gross negligence
11 subjected patient N.Y. to pain, discomfort and with risks attendant in having a retained lap sponge
12 as set forth in paragraphs 10 through 14, above.

13 SECOND CAUSE FOR DISCIPLINE

14 (Incompetence – Incorrect Sponge Count)

15 16. Respondent is subject to disciplinary action for incompetence under section Code
16 section 2761, subdivision (a)(1) in that she failed to accurately complete the final lap sponge
17 count, did not identify the loss of a lap sponge and failed to notify the attending surgeon of the
18 incorrect sponge count as set forth in paragraphs 10 through 14, above.

19 PRAYER

20 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
21 and that following the hearing, the Board of Registered Nursing issue a decision:

22 1. Revoking or suspending Registered Nurse License Number 450436, issued to Floribel
23 Briosos Diaz.

24 2. Ordering Floribel Briosos Diaz to pay the Board of Registered Nursing the reasonable
25 costs of the investigation and enforcement of this case, pursuant to Business and Professions
26 Code section 125.3.

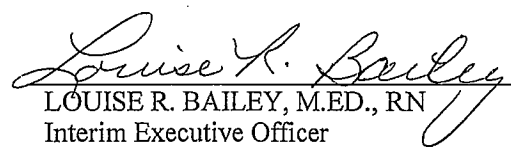
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3. Taking such other and further action as deemed necessary and proper.

DATED: 5/25/10


LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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